



MISSOURI HEALTH
COORDINATING COUNCIL

HEALTH LEADERS SUMMIT MEETING SUMMARY

prepared by
the State Health Planning and Development Agency

MISSOURI DEPARTMENT OF HEALTH
JEFFERSON CITY, MISSOURI
OCTOBER 14, 1986

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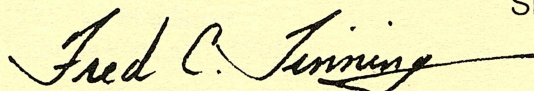


INTRODUCTION

Leaders in Missouri's health care industry were invited to participate in a "Summit Meeting" held on October 14. The Missouri Health Coordinating Council (MHCC) through the State Health Planning and Development Agency sponsored this meeting to give leaders of major public and private organizations a forum for the discussion of their long-range health plans and short-term priorities, as well as an opportunity to consolidate a partnership for refocusing health planning in the state. Twenty-seven persons were present representing ten state agencies and twelve private organizations.

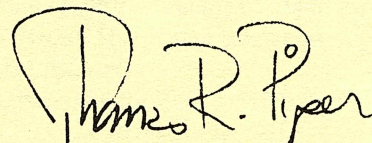
The MHCC submitted seventeen priorities of which the following eight were most frequently discussed: indigent care & insurance; financing of health care, especially the financing of long term care; malpractice insurance; the continuum of care; health prevention programs; substance abuse; maternal and child health, particularly the issue of teenage pregnancy; and health manpower.

Health planning is not a static endeavor. We invite you to read the following summary of participants' comments. For health planning to succeed, health leaders, like yourself, need to join together and share their priorities and concerns with other leaders in the health care industry in order to develop strategies for resolving some of the difficult issues facing the Missouri health system. This Summit Meeting was a step in this direction. The MHCC and SHPDA trusts this Summit will be the first of many cooperative meetings.



Dr. Fred Tinning, Chairman
MHCC

Sincerely,



Thomas R. Piper, Manager
SHPDA

Summit Meeting Attendance List

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MHCC Officers:
William Wilson, Chairman
Dr. Fred Tinning, Co-Chairman
Dr. George Selfridge, Parliamentary Advisor

SHPDA Staff: Thomas Piper, Manager; Dan Eckles; Linda Hillemann; Bob Haynes; and Greg Stratman



Health Issues For Missouri

Participants' Comments



HEALTH ISSUES FOR MISSOURI

Summit Participants Comments

The following narrative includes a short summary of the topics discussed by the summit participants. The numbers in parenthesis after each heading indicated the number of times the issue was raised by an individual summit participant.

A. Financing Health Care

Both the public and private sectors voice the need for new approaches to health care financing. The increasing numbers of uninsured, the sagging agricultural economy, the spiraling costs of health care to both the public and private sectors, new approaches to public sector funding and numerous other factors have placed undue strain on all sectors of the health care industry. Some of the most significant issues confronting the health care system are financial and affect the delivery of both health care and health support services. Most experts believe that a concerted public/private sector approach to health care financing is the most feasible solution.

1. Indigent Health Care (11)

This issue is a high priority for both the public and private sectors. The provision of care to the medically indigent has placed a high degree of fiscal stress on both private and public health care providers. Not-for-profit facilities have been particularly burdened with the doubling of charity care from 1980 to 1984. Payments for health care services targeting the medically indigent comprise nearly \$2 billion per annum of the state operating budget. Despite these efforts, from 7% to 12% of the medically indigent have reported barriers to care during 1985.

Comments: Summit participants discussed a wide range of issues concerning indigent health care, such as the frustrations of clients and providers in accessing public services. The Department of Social Services(DOSS) gave services to 750,000 people in Fiscal Year '86. With federal cutbacks pending, DOSS is expecting its largest general revenue expansion item for this legislative session to be funding to cover those funds lost from the federal Medicaid match. These HCFA changes may also negatively impact Missouri's Medicaid program by lowering the match rate on all optional services such as long term care, dental services and pharmaceutical services. Medicaid reimbursement to physicians has long been considered inadequate. Unless a way can be found to increase physicians fees, many physicians may withdraw from the program. Public funding for prenatal care is also inadequate to meet the need. In addition, increases in Medicaid funds were frozen for increasing dental fees and initiating a preventive dental sealant program. Quality of care is compromised by budget cutbacks. Because of the inadequacy of public funding, we are actually rationing care to the poor.

Summit participants also examined the need to increase Medicaid long term care reimbursement rates. There are currently 28,000 long term care Medicaid patients with an average cost of \$42 per patient day and a range of \$30-50 per patient day. A one percent increase in the reimbursement allotment is only an increase of 42 cents per patient day for the provider, but a \$1 million increase in the Medicaid budget.

There is also a need to increase Medicaid funding for medications and equipment for chronic conditions such as arthritis. Forty percent of persons who need the arthritic medication of choice, aspirin, cannot get it on

the Medicaid formulary without a lot of extra paper work by physicians. Arthritis sufferers will wind up hospitalized at greater costs than that of preventive treatment because the medications were not available. Additional state funding is also needed for treatment of mental illnesses and disabilities, and to provide state funding for public school health education and services.

The question of funding for services involving the homeless and economically pressed rural areas was also reviewed. The lack of food and shelter for the homeless are major health problems which will ultimately result in higher utilization of public institutions such as public hospitals, correctional facilities and programs and facilities of the Department of Mental Health.

The current rural economic crisis has further intensified the difficulty of accessing public aid services. Farmers may have a negative cash flow, and a negative net worth, yet because they technically own land, they cannot qualify for relief. Farmers, as a group, are often very hesitant to accept free care, charity or mental health services and social services personnel are not equipped to deal with the new farm poor, who have often been community leaders but are now destitute. Family planning clinics and family planning agencies are sometimes the only primary care service rural poor can access. Approximately 95% of the clientele of family planning clinics are below 150% of the poverty criterion.

While the funding problems are widespread and significant, beginning or expanding health services is very difficult, given the limited tax base and the Hancock Amendment restrictions on increasing that base. In these times we need to be as imaginative in documenting sources of resources as in documenting needs.

In order to enhance the delivery of indigent health care services, several program ideas were discussed, such as the proposed MedAssist legislation; Senior Care, a program in Missouri where dentists provide all dental care to senior citizens at 25% discount, and additional financial support for family planning clinics, such as by allowing reimbursement through Medicare's DRG system.

For those in need in rural areas, there were additional suggestions. Various economic relief services often have different eligibility requirements. It was suggested that these be made uniform from one program to another so that once a family qualified for one program, they automatically qualify for others. Another suggestion was that eligibility be set at a certain level of negative net worth, for example 60%. At this level, even selling the assets such as land and equipment would leave a farm family destitute, in debt, and probably without shelter.

2. Health Care Insurance (2)

The Department of Social Services, the Department of Health and the Missouri Hospital Association have placed a very high priority on this issue. Approximately 617,000 Missourians did not have health insurance in 1985, and an estimated 36,000 others have been "wiped out" due to catastrophic illnesses. Uncompensated care provided by both public and private hospitals has nearly doubled from 1980 to 1984.

Comments: Summit participants seemed to feel that there is a place for more third party reimbursement for mental illness, disabilities, dental services, long term care and catastrophic illness. Contributing factors such as unemployment and low wages result in delaying treatment until a health crisis erupts. In addition, 60% of rural clientele are uninsured.

Health insurance for Missouri's state employees is a big budget item. Some costs savings might be realized through more focus on health promotion and disease prevention incentives.

Worker's compensation is another large budget item. Injured workers need more employer involvement in their rehabilitation. In so far as possible, employers should be encouraged to keep their handicapped employees active with light duty work during the period of their rehabilitation. Nonwork becomes debilitating; it exacerbates stress and physical problems. This is another area in which the state could realize some cost savings, such as by pooling funds with the private employer to keep an injured employee on the job. The Department of Elementary and Secondary Education vocational rehabilitation should be reserved for those without employer resources.

3. Health Cost Containment (3)

Providers from both the public and private sectors, as well as consumers, have called for action to control spiraling health care costs. Health costs in Missouri have tended to exceed the national average. For example, in 1983 Missouri had the third highest community hospital costs per capita in the nation.

Comments: Summit participants emphasized that prevention could be used as a method of cost containment. In addition, pharmacists could assist in cost containment measures by augmenting physician treatment through monitoring and encouraging patients to comply with chronic care treatment. The self-treatment of minor ailments could also be augmented by pharmacists.

Issues such as utilization review are important. Current low utilization rates do not accurately reflect the true medical need of clients. The nursing home moratorium as a health cost containment measure has created a "catch-22" situation. An observation was made that the moratorium was not needed when it was first established, but today it is needed due to a pent-up desire to build. Because of the moratorium, a natural market does not exist. If the moratorium were lifted now, adding to excess capacity would result in many bankruptcies by existing facilities.

4. Prepaid Health Care Systems (2)

The Departments of Health and Social Services have placed high priority on the development of prepaid health care systems such as health maintenance organizations and preferred provider organizations. Experience has revealed that one of the best methods to control health care costs is through organizations which emphasize preventive as opposed to remedial health care. The Department of Social Services has implemented a prepaid program for 26,000 Medicaid recipients in the Jackson County area that has been successful. There are now 15 HMOs in Missouri.

Comments: Reservations about wholesale endorsement of prepaid systems were expressed by the summit participants who indicated, that while there is a place for them, they are not a cure-all for slowing the cost spiral in the health care industry.

5. Economic Viability of Services (1)

Changes in the reimbursement structures of major funding sources has affected the ability of many services to continue providing their services. Hospitals are seeing lower utilization rates and lengths

of stay; home health agencies find themselves in an increasingly competitive market with few controls on the range or quality of services offered. Many services are seeking new means of funding, including diversifying into other forms of service delivery.

In particular, reimbursement under the Medicare DRG program appears to be inadequate. Program management needs to become aware that economics are becoming tighter and service providers are finding it harder to deliver services at present reimbursement levels.

Comments: Home health services, rural hospitals and public hospitals are all finding increasing problems in maintaining levels of service under the Medicare DRG program. Some face heavy budget deficits and even closure as a result of inadequate reimbursement.

Reimbursement for some nontraditional services such as nurse practitioners could provide some cost savings if they were recognized by the reimbursement programs.

B. Distribution of Health Care Services

Once a person becomes ill, access to the proper level of medical care is essential to restoring the person to full health. While Missouri has a wonderful array of health services, they are not always distributed across the state in a way which best serves Missourians. Economic conditions often play a vital role in stimulating or impeding the growth of an appropriate mix of health services.

1. Rural Health (9)

The Department of Health and private sector organizations, such the National Rural Health Care Association, have recognized the crisis in rural health. Due to radical economic losses in the agricultural industry for the past several years, a rash of health-related problems have arisen including increased mental stress, increased suicides, increased child and elderly abuse, loss of health care professionals in rural areas and increased fiscal stress upon rural hospitals and other rural health care facilities.

Comments: Summit participants noted the severe effects of emotional stress on health triggered by the sagging rural economy where five out of ten farms in Missouri are failing. These effects include high divorce rates, family stress and disorganization, financial stress on families, increased alcoholism, and an increase in teen pregnancies. Many families have been forced to drop health insurance coverage. This loss of health insurance results in a greater risk for medical indigency. In addition, to save money, families neglect preventive or primary health care until a health problem too serious to ignore and chronic illnesses become catastrophic illnesses. The rural economic crisis has further complicated the financial problems in the health system noted earlier, contributing to rural health facility failures and the loss of health care professionals such as OB specialists from some rural communities.

2. Maternal and Child Health Services (1)

Numerous public, private and voluntary agencies and organizations place the need for intensified and expanded maternal and child health services high on their lists of priorities. Much of this emphasis has been placed upon the need for increased prenatal care. The incidence of inadequate

prenatal care is extremely high in some areas of the state (more than 25% of the pregnant women in 36 counties in 1983-84). This circumstance gives rise to increasing numbers of low birth weight babies, complications of pregnancy and other health care problems that increase both health care costs and physical and psycho-social suffering. This problem is further magnified by rising medical liability costs imposed upon OB/GYN physicians. The need for services to children of all ages is further emphasized by the fact that children comprise the largest percentage of the ranks of the medically uninsured in Missouri. The increase of teenage pregnancy is also a major concern in this context.

Comments: Summit participants saw a need to bolster public maternal childhood health programs as well as provide adequate prenatal care particularly for teenage mothers.

3. Health Manpower (2)

The shortage of health manpower in rural and low income areas is of major concern to public and private organizations involved in the provision of health service to these populations. A maldistribution of physicians, and in particular of primary care physicians, is evident. Approximately 50 Missouri counties and several urban areas are in need of more primary care physicians. The decrease in physicians providing OB/GYN services due to escalating costs of medical liability has further intensified the shortage.

Comments: Summit participants related that the decrease in physician manpower in rural and low income areas, particularly the decrease in OB practice, is a result of the medical liability issue. This problem is further complicated with the difficulty of finding physicians who accept Medicaid patients.

Although the demand for dentists is low, the summit participants saw an adequate supply of dentists to meet the service demand in Missouri with some pockets of low supply in poor and low density areas of the state. Dental manpower distribution is complicated by medical indigency which further reduces the demand for dental services.

Regarding the nursing profession, summit participants saw a need for adequate training for nurses delivering high tech home health services. The Missouri Nurses Association would like to see nursing education reach a higher standard of education by 1995, although others noted that the success in the implementation of these standards will have major cost implications for the health system. The Missouri Nurses Association disagrees with this assumption for the lack of data. While there is a scarcity of nurse practitioners and qualified RNs, LPNs, and aides for long term care facilities, there seems to be an adequate distribution of public health nursing services throughout the state.

The distribution of pharmacists is changing. More new practices are starting in institutional settings rather than in community retail pharmacies. The shift from male to female professionals who tend to prefer institutional practice, and the high inventory costs associated with retail practice have been discouraging the spread of non-institutional practice.

Concerning health professional education, federal cutbacks have resulted in higher educational institutions assuming a greater role which will in the future impact both on the training programs and the students. The Board is urging Missouri institutions to carry out their basic missions at high quality levels and not branch off into marginal areas. The distribution of allied health professionals appears to be adequate, but there are some pockets of low supply in poor and low density areas in the state. A study of allied health

distribution and education needs has been completed recently by the board.

Additional discussion centered on the need for a school of public health. The need for community and public health services is growing and it was noted that there is a tendency for trained persons to settle in the areas in which they received their final training. There are currently no plans or recommendations to fund public health education in the state university system, however contractual arrangements could be made with other states to provide limited services or education programs for specialized training. Kirksville College of Osteopathy is opening a community health program.

4. Medical Liability (9)

The medical profession, the health care industry, the Department of Social Services, the Department of Health and others cite the increasing costs of medical insurance premiums and losses due to malpractice litigations as a major issue. From 1979 to 1984, physician malpractice insurance losses increased approximately 200%, while hospital losses increased more than 2,000%. Due to increased liability costs many physicians have discontinued the provision of OB/GYN services, which has created serious access problems in several areas of the state.

Comments: Summit participants were very concerned with the issue of medical liability. Physicians providing primary care, family planning and OB services are finding it increasingly hard to serve in these areas due to profound increases in liability insurance rates. Hospitals have also been hard hit. Other professions such as dentists and oral surgeons have also had difficulty finding a carrier and have had to raise their fees to cover increases in their insurance premiums. Mobile dental units serving low density and poor income areas have been discontinued because of liability costs. The issue of medical liability has also confronted health services students and teachers. Pharmacist liability is also rising, but the problem is not as critical for them as for other health professionals.

5. Public Health Services (1)

The economic stress placed upon the health care industry due to the increase in uncompensated care, public sector cutbacks, growing numbers of medically indigent and other circumstances has been particularly severe in the public sector. For example, statistics reveal that much of the uncompensated care burden has been borne by public hospitals. At the same time, under-funded and understaffed local health departments are, particularly in rural areas, called upon to provide more and more services. The Department of Health advocates the need for joint public/private sector ventures to address these issues.

Comments: An opinion was offered that uniform health services should be offered in Missouri schools to form the basic core of child health screening services.

6. Long Term Continuum of Care (1)

Health care professionals from numerous public and private agencies cite the care of the aged and chronically ill as the major issue. Payments to meet the medical needs of this sector of the population comprise a large percentage of the state budget and a large portion of private sector losses. The numbers of Missourians over age 75 is projected to increase to more than 300,000 by

the year 2000. Since this is the age group most often needing health care services, a greater demand can be expected. It is generally recognized that a comprehensive study must be done to determine the need for and distribution of resources to meet the needs of the aged and chronically ill.

Comments: Long term care was described as the largest single state budget item. Participants stressed the need for the development of quality assurance standards for home health services. Long term care services are not only for the aged. People with disabilities from congenital defects or injuries also require services from the long term care continuum. Additional needs are found in institutions such as prisons and mental hospitals which house people who may also require long term health care. Ironically, the Medicare prospective reimbursement system, which has been designed to restrict the growth of hospital cost and over-utilization, has resulted in a much more sick long term care clientele. When discussing bed-need distributions, it was noted that there is a fine line between good planning and over-restriction of beds.

In regards to the issue of quality control, there is a desire to revise antiquated licensure laws of both professions, such as physicians, nurses and services such as hospitals and nursing homes. In addition certain professions such as dieticians and nutritionists should be regulated but currently are not. Summit participants would like to see higher professional-to-client ratios in mental health institutions, as well as a better outreach system, for mental health services, especially in the rural areas of the state. In rural areas, disabled persons also have difficulty accessing health services, particularly because of the lack of transportation services that meet their needs. Quality of health professional practice in correctional institutions is effected by confidentiality issues. Dual licensing requirements in Missouri "border" towns, such as Kansas City or St. Louis can further complicate an institution's health service delivery.

C. Distribution of Health Support Services

The health care system is set up to cure disease or restore from disability. Yet there is a wide range of services at both the community and individual level designed to maintain health by preventing the onset of illness and disability, encouraging the pursuit of healthful lifestyles, and creating healthful environments in which to live and work. Some major issues pertaining to health support services are described below.

1. Preventive Health Services (2)

Preventive health services are high among the priorities cited by the Board of Health and the Department of Health. Specific issues recommended for immediate attention are pregnancy and infant care, family planning, high blood pressure control and preventive dental health services.

Comments: Summit participants outlined their concerns for improving health screenings particularly in blood pressure, cancer, nutrition, anemia and programs for the prevention of mental illness and mental retardation. The rise of rural teen pregnancies was noted. This problem is intertwined with other social issues such as child abuse, poor parenting skills, child support enforcement, and adequate prenatal care. One third of family planning clients are teenagers.

Public health is the traditional proponent of prevention. There is a need to reestablish the concept that

public health supports all citizens who need to be more conscious of the need for prevention. Funding needs to be increased for prevention programs and to local public health units. Only 6 cents per person per day is spent on public health. Dental services such as the dental sealant program need to be expanded. Dental problems are a leading cause of school absenteeism in the state.

2. Health Promotion (Lifestyles) (2)

Health promotion has been cited as one of the most effective and efficient means to deal with the control of health care costs while maintaining a high quality of life. Chronic disease prevention/risk reduction, reduction in the misuse of alcohol and drugs, smoking cessation and stress control are recommended by the Board of Health and the Department of Health as specific areas demanding attention. A strong emphasis has been placed upon the need for joint action by the public and private sectors.

Comments: Summit participants conveyed the need to develop and implement comprehensive health education programs in the schools as well as in the work-site.

3. Substance Abuse (4)

Programs to address alcohol and substance abuse, particularly by children and adolescents, are high on the lists of priorities of the Departments of Public Safety and Mental Health, and numerous citizen organizations. The Department of Public Safety reports that alcohol and substance abuse are involved in a large percent of motor vehicle accidents and violent crimes resulting in bodily injury or homicide.

Comments: Summit participants stated that with the increase in federal money coming into the state for substance abuse, new programs should be developed to curb the abuse of tobacco, alcohol and drugs, including misuse and diversion of prescription drugs. Drug and alcohol abuse have a significant impact on crime and corrections. Most offenses are drug or alcohol related. Either the offender commits the crime under the influence of drugs or alcohol, or the crime is committed to support the drug habit. Drug abusers also have a higher recidivism rate.

4. Health Protection (2)

The Departments of Public Safety and Natural Resources, and the Board of Health have identified the improper transportation and storage of hazardous waste materials as a major health threat. Other environmental issues cited are water quality, toxic agent control, infectious agent control and accident and injury control.

Comments: Summit participants agreed that the utilization of seat belt and child restraint systems has increased dramatically. The Department of Public Safety has primary responsibility for monitoring the transportation of hazardous material through the state and for preparing for civil defense.

5. Communicable and Infectious Diseases (1)

The Department of Health cites the control of communicable and infectious diseases, and in

particular sexually transmitted diseases, as a major area of concern. The increasing incidence of AIDS is cited as evidence for a concentrated effort in this area.

Comments: The Summit participants stressed that the control of AIDS is becoming a major issue. The Department of Health and the Department of Mental Health should undertake efforts in a cooperative venture to control transmission of the disease through intravenous drug abuse between infected persons.

D. Biomedical Ethics

The need for further study of the thorny issue of biomedical ethics has been cited as a high priority by all health care professionals. The rapid advance of medical technology and the ability to increase the lifespan via the use of such technology, coupled with issues such as family planning and abortion, has given rise to complex problems involving social, economic and spiritual values.

Comments: No comments or issues were raised regarding this issue by summit participants.

E. Health Planning (3)

At the time of the Summit, the federal health planning program was in jeopardy and has since been discontinued. Yet in Missouri, the program is a valuable resource in limiting the health care cost spiral and in providing information on the health care system in Missouri. New funding alternatives will need to be found to continue the program and these alternatives are currently being explored. In the meantime, we are on the brink of a new era for health planning. While federal funds are no longer available, there are also no federal program requirements. This creates the unique opportunity for the Missouri health planning program to develop in ways that are more meaningful for the state. The Missouri Health Coordination Council is considering changes to their mission and their activities to promote a healthier life and stronger health care system for Missourians.

Comments: When asked about the components of the health planning program that should be continued or revised, several suggestions were raised. First of all, it was felt that the need to get grassroots input in shaping the new health care system is very important. Changes in the health care system are marked and will continue to be made rapidly. The perspective given by the consumer is more important now that the health system is having to respond more and more to financial restrictions.

It was also noted that better coordination is needed to make existing services more accessible. In addition, demographic changes are going to have a heavy impact on the future of the health care system and the kinds of demand placed on it. In particular, the pending significant increase in the number of frail elderly will impact the whole health care system both in terms of demand and cost.

KEEPING IT IN CONTEXT

In mid-1986, the Executive Committee of the Missouri Health Coordinating Council (MHCC) established a specific set of assumptions and objectives to guide the MHCC's future course. This set is listed below:

- A. The MHCC's constituencies consist of all providers and consumers of health care;
- B. The MHCC's major objective is to develop a health plan that represents all constituencies;
- C. The MHCC's consensus-building activities will include:
 - 1. Identifying participants and soliciting ten health care priorities with recommendations and supporting documentation from each by:
 - a. Meeting with the governor, speaker and other public officials and leaders to discuss their major health concerns;
 - b. Holding a "summit meeting" with public and private leaders, e.g., state agency heads, association heads and executive directors;
 - c. Conducting regional public hearings.
 - 2. Assembling information into priority documents, such as reports from agencies and task force committees, on such topics as indigent care, and to categorize into subsets (i.e., ten priorities for each - primary, secondary and tertiary issues);
 - 3. Developing progress reports in the form of "white papers" for distribution to identified contacts;
 - 4. Subdividing the council into task forces and ad hoc groups for each major priority area;
 - 5. Utilize previous State Health Plan materials; and
 - 6. Present a State of the Council Annual Report at the end of the year.

Of particular interest in this context is the establishment of a list of health priorities (part C.1. above), of which this summit meeting has been a part. Meetings with the governor's office and Speaker Griffin were other important parts of this consensus-building process; therefore, we are including a summary of these meetings in order to provide a complete picture.

On September 12, 1986 - the MHCC Executive Committee met with Richard McClure, the governor's Chief of Staff. Topics of discussion included:

A. Confirmation of Charge from Executive Order 86-4:

If changes occurred in federal funding, Mr. McClure requested the MHCC to advise the governor on what changes would need to be made in the existing executive order to allow the MHCC to do what it feels it should within constrained resources.

B. Priority Health Issues of the Administration:

Mr. McClure informally listed the following issues:

1. Prevention, targeting long-term health risks;
2. Strong local public health;
3. Prevention/Protection such as related to environmental risks, smoking, alcohol-drug abuse; and
4. Adequate levels of institutional and non-institutional health services such as for indigent populations;

C. Developing a Partnership for Planning:

1. Plan Development and Implementation:

- a. Mr. McClure stated that the administration needed and desired some form of input from the public, health experts, and front-line workers for state policy on major health issues;
- b. financing for health planning is a problem.

2. Seeking Public Input:

- a. Meetings with legislative leaders:
The best role for the MHCC may be to help articulate and document problems for the legislature.
- b. Summit Meeting:
Mr. McClure was interested in the summit meeting and will encourage cabinet members to attend.
- c. Regional hearings:
Funding restrictions pose a significant problem and holding hearings at this time may stimulate false expectations within the public arena if we had no resources with which to follow through. The group decided these hearings should be postponed until there is a better feel for MHCC financing.

On December 16, 1986 the MHCC Executive Committee met with Speaker Bob Griffin to discuss his major health concerns:

- A. Rural Health Care, Indigent Care and Organ and Tissue Transplants were areas of special concern for Mr. Griffin. He said the state needs to assume some responsibility for providing for these programs.
- B. The speaker expressed concern about MedAssist and suggested these changes:
 - 1. It needs to be affordable;
 - 2. It must not create another level of bureaucracy;
 - 3. It must *not* be perceived as another welfare program;
 - 4. It should address the needs of people above the poverty level; and
 - 5. It might be paid for by the windfall tax.
- C. The speaker suggested that the MHCC invite legislators from both the senate and the house, as well as members of both political parties, to match their interests with future MHCC projects. This would provide linkages so these projects can become official policy.

The MHCC was very pleased with the participation and very helpful attitude exhibited in both of these meetings.

On October 14, 1986 the MHCC and the SHPDA facilitated the gathering of health care leaders from the public and private sectors at the same table for the purpose of sharing their organizations' health priorities, long-range plans and common interests. We believe that there is a place for a continuation of this dialogue. Opportunities for the advancement of the health care delivery systems exists, but partnerships must be formed between the public and private sectors for the purpose of promoting effective solutions to common problems.

WHERE DO WE GO FROM HERE

The Missouri Health Alliance was formed as a means to keep this dialog continuing. Through the Missouri Health Alliance, leaders in the health care industry will have a forum in which to gather and exchange important and timely information.

Specifically, the MHCC and SHPDA encouraged the Alliance to meet before each legislative session and again after the legislature adjourns to discuss successes and challenges, and to plan for the future!

As leaders in the health field, we can join interests through the Missouri Health Alliance to provide this forum.

The Missouri Health Coordinating Council looks forward to your continued interest and involvement. We will utilize all of our resources to provide you with the tools necessary to make sound decisions affecting the welfare of Missourians.

Missouri Health Coordinating Council Members

Dr. Fred Tinning, Ph.D., Chairperson
Kirksville, Missouri
Provider Representative
Term Expires April, 1988

Fred Speckmann, Vice-Chairperson
Afton, Missouri
Consumer Representative
Term Expires April, 1987

George Selfridge, D.D. S., Vice-
Chairperson
Chesterfield, Missouri
Provider Representative
Term Expires April, 1989

Clifford Graham, Parliamentary Advisor
St. Louis, Missouri
Provider Representative
Term Expires April, 1989

Nancy Barr, R.N.
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Kansas City, Missouri
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Chelmer Barrow
Moberly, Missouri
Provider Representative
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Richard Biery, M.D.
Kansas City, Missouri
Provider Representative
Term Expires April, 1989

Mrs. Robert Brown
Canton, Missouri
Consumer Representative
Term Expires April, 1990

Suzanne Burch
Sikeston, Missouri
Consumer Representative
Term Expires April, 1989

John (Tom) Carson
St. Louis, Missouri
Veterans Administration Representative
Perpetual Term (Ad Hoc Member)

Rev. Elbert Cole
Kansas City, Missouri
Consumer Representative
Term Expires April, 1990

John Kissel, M.D.
St. Louis, Missouri
Provider Representative
Term Expires April 1990

Jane Kruse
Columbia, Missouri
Provider Representative
Term Expires April, 1987

William McDonald
Springfield, Missouri
Consumer Representative
Term Expires April, 1988

Thomas M. O'Sullivan, Sr.
Lamar, Missouri
Consumer Representative
Term Expires April, 1989

Kent Rissman, Ph.D.
St. Louis, Missouri
Consumer Representative
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Jack Whitaker
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